APPENDICES

Objectives/Strategies by Goal

Goal 1: Increase the percentage of South Carolinians who meet the current age-specific recommendations for regular physical activity.

Objective 1: By July 31, 2008, at least 50 worksites in SC will promote physical activity for employees.

Strategies

1. Employers will encourage daily physical activity by implementing strategies such as providing easy access to stair-wells while limiting access to elevators, supporting and promoting lunchtime walking/ running clubs or company sports teams, and providing on-site facilities such as walking trails and bike racks.
2. Increase the number of worksites providing weight-related physical activity educational materials to employees based on current, evidence-based information.
3. Employers will provide opportunities for employees to become engaged in self-management and goal setting relative to physical activity.
4. Employers and businesses will promote and support community efforts to reduce TV time and increase physical activity, such as "Turn off TV Week" and "Walk to School Day."
5. Employers will be provided resources to implement low cost, incentive-based physical activity programs.
6. Employers will be provided with a list of non-profit agencies that can provide low or no-cost educational materials.

Objective 2: By December 31, 2008, at least 25 worksites in SC will have adopted policies supportive of physical activity.

Strategies

1. Provide flexible scheduling to allow employees to participate in exercise before work, during lunch, or after work.
2. Provide reimbursement for employees who are members of exercise facilities or participate in classes.
3. Provide discounted rates for membership to fitness and recreation facilities.
4. Provide incentives to employees participating in physical activity programs.
5. Provide up to 3 hours of paid time per week for employees to participate in physical activity.

Objective 3: By July 31, 2008, at least 92 free, sliding scale or publicly owned recreation facilities will be identified.

Strategies

1. Assess recreation centers in South Carolina to determine which need improvements or need brand new facilities.

Action Steps:

- *Secure funding for assessment development and implementation.*

- *Work with SCRPA, which periodically polls its membership about needs and assets in local park and recreation departments.*
- *Work with SC PRT, which develops a five-year state outdoor recreation plan.*

2. Develop a best practice resource tool to help communities develop comprehensive recreation and fitness centers.

3. Support and build advocacy to identify and establish a permanent funding mechanism for public park and recreation agencies to fund new recreation centers for the entire state.

Objective 4: By July 31, 2010, at least 46 non-public recreational facilities will be open to community use.

Strategies

1. Increase the number of school districts that allow community use of schools for recreational activities (e.g., walking tracks, outdoor fields, gyms).

Action Steps:

- *Assess district policies on public use of school recreation facilities, (for example, USC PRC work via a CDC Special Interest Project).*
- *Develop a model policy that addresses issues of maintenance and liability.*
- *Work with the Department of Education and school board association to encourage districts to adopt policies allowing public use of school recreation facilities after regular school hours (evenings and weekends).*
- *Work with the Department of Education or school board association to identify old schools available for adaptive reuse as community centers with recreation facilities.*

2. Work with faith-based groups to find ways to increase community use of church recreational facilities.

Objective 5: By July 31, 2010, at least 46 communities will have free, sliding scale, or publicly funded physical activity opportunities.

Strategies

1. Work with SCRPA to identify needs and develop plans with their membership.

2. Work to identify funding sources to provide community physical activity opportunities.

3. Implement Hearts N Parks programs or similar programs in local recreation departments.

4. Survey current mall walking programs. Develop tools to help these programs advertise and increase participation.

5. Develop tools to promote new mall walking programs (for example, Sumter County Active Life-styles Heart and Soles Mall Walking Program).

6. Develop a tool for communities to implement activity components into local festivals and community events.

7. Create a directory for physical activity resources in the community. Identify and distribute information about walks, runs, and other physical activity opportunities held in communities across the state.

Objective 6: By July 31, 2008, at least 20 communities will develop partnerships with stakeholders such as hospitals, municipal associations, and city and county councils, to collaborate on locally based physical activity initiatives and policy changes.

Strategies

1. Work with SCCPPA to identify local coalitions focused on physical activity.
2. Develop a toolkit to assist communities in developing local physical activity coalitions.
3. Provide networking opportunities for the sharing of resources for local coalitions throughout the state.

Objective 7: By July 31, 2010, at least 20 communities will have connectivity to at least 10 miles of sidewalks, walking trails, bike lanes/paths and other features of the built environment conducive to safe physical activity.

Strategies

1. Coalitions, in partnership with city planners and developers, will conduct walkability audits in the community.
2. Add bike lanes on at least 2 renovated roadways in South Carolina**.**

Action Steps:

- *Work with SC DOT and Metropolitan Planning Organizations throughout the state to establish a baseline assessment of existing and needed bike lanes.*
- *Work with SC DOT/ MPO planning processes to prioritize construction of bike lanes.*

3. DOT or local jurisdictions will have plans to add sidewalks where needed, especially leading to schools, recreation departments and other physical activity sites.

Action Steps:

- *Work with SC DOT and Metropolitan Planning Organizations throughout the state to establish a baseline assessment of existing and needed sidewalks.*
- *Work with SC DOT and MPO planning processes to prioritize construction of sidewalks.*

4. Increase the number of continuous sidewalks/walkways/bike lanes on main streets (with high connectability) in 3 cities.
5. Modify/assess MPO current organizational structure and develop policy requiring that bike/pedestrian coordinator be actively involved in MPO decision making.

Action Steps:

- *Survey MPO's to identify which have advisory groups and/or bike/pedestrian coordinators, how they are used, model policies/job descriptions.*
- *If necessary, contact MPO's in states with good bike/pedestrian policies (e.g., Oregon) to use as models for South Carolina recommendations.*

6. Local municipalities and counties will develop and adopt ordinances that require sidewalks and bike lanes in new subdivisions.

Action Steps:

- *Identify model ordinances in South Carolina or elsewhere.*
- *Work with SC Municipal Association and Association of Counties to develop a model ordinance for recommendation to local communities.*

7. Promote "Share the Road" signage and culture and other bike/pedestrian safety education programs.

Action Steps:

- *Partner with Palmetto Cycling Coalition, which is working to promote a "Share the Road" culture and a school-based bicycling curriculum in South Carolina.*

Objective 8: By July 31, 2007, implement *America On the Move* in South Carolina.

Strategies

1. Partner with SCCPPA, SCPRA, YMCA, AARP, DHEC, and other programs to promote *America on the Move*.
2. Research other state models for collaborative approaches with *America on the Move*.
3. Develop strategies for engaging hard-to-reach populations in *America on the Move.*

Objective 9: By December 31, 2007, at least 150 faith based settings will support physical activity through programs and/or policies.

Strategies

1. Establish a baseline number of Faith-Based Settings (FBS) that offer programs and have policies, either formal or informal, that support physical activity.
2. Promote partnership with recreation facilities and community activities, through use of co-facilities (work with PA subgroup) and communication network (for PA classes, chair aerobics etc.) at FBS.
3. Increase the number of faith-based child care centers implementing the *Color Me Healthy* curriculum.
4. Encourage increased participation in physical activity for youth (e.g., sports, dance).
5. Promote family physical activity (e.g., walking, biking).
6. FBS with established physical activity programs will engage in community outreach to promote physical activity.

Objective 10: By December 31, 2007, at least 50 schools will provide opportunities for students to participate in physical activity during the school day.

Strategies

1. Establish/adopt state level policy that requires and funds Physical Education Program Assessment for grades K-8.
2. Establish state level policy that requires 150 minutes weekly of physical education in grades k-5.
3. Establish state level policy that requires 250 minutes weekly of physical education in grades 6-8 (NASPE's recommendation for Middle grades).

4. Establish state level policy that requires three Carnegie units of physical education for high school graduation.
5. Provide models for increasing PE time in grades K-8, middle and high school
6. Provide training to elementary schools to implement walking programs (such as Duck Walking, Walk Across America, Walk For Life).
7. Disseminate the SC Governor's Council on Physical Fitness' Recess Policy Statement to all middle and elementary school Principals.
8. Provide training and distribute model programs to middle and high school Principals for implementing intramurals, physical activity clubs, and physical activity elective courses into the school day. (Work with the Middle School Association)
9. Provide training to Physical Educators on implementing the SC Physical Education Standards and Assessment Program. *(Partner: SDE and SCAHPERD- SCPEAP)*
10. Provide training to district and school personnel on increasing physical activity opportunities into the core curriculum ("Take 10" program).
11. Increase the active time in physical education classes to 90%.of class time.

Objective 11: By December 31, 2008, at least 50 schools will provide opportunities for faculty and staff to participate in physical activity at school.

Strategies

1. Create a packet of model staff physical activity program ideas and disseminate these to all elementary, middle and high schools (or school districts). (Partner with Prevention Partners and DHEC's Capital Health Program).
2. Provide presentations on staff physical activity programming at school related conferences (middle school, school nurse, etc.) *Work with SC School Administrators.*
3. Provide school districts and schools with model policies and programs that encourage faculty and staff physical activity (such as the use of recreational/sports equipment in the school).

Objective 12: By month December 31, 2008, increase the percentage of children that walk or bike to school.

Strategies

1. Work with YRBS or YTS to add appropriate question(s) to survey.
2. Identify schools in SC where it is physically possible and potentially safe to begin a Safe Routes to School Program.
3. Provide grants/resources to identified schools (through the SC Governor's Council on Physical Fitness and the SC Coalition for Promoting Physical Activity) to participate in Walk to School Day.
4. Disseminate information to all school Superintendents and Principals on the Safe Routes to School bill and Walk To School Day.
5. Provide training to school administrators on model policies and programs to implement a Safe Routes To School program (SCASA Conference).
6. Provide resources to identified schools on how to set up a SR2S committee (SCCPPA Fall 2005 SR2S Conference).

Objective 13: By December 31, 2010, at least 150 school and community members will be identified as leaders in improving school physical activity.

Strategies

1. Provide training to school administrators on the SC Physical Education Assessment Project at the SCAHPERD Conference.
2. Provide a one-day training to potential school health leaders through the SC Healthy Schools Leadership Institute.
3. Provide a weeklong training to school health teams for implementing the CDC's School Health Index through the SC Healthy Schools Summer Leadership Institute.
4. Work with existing awards processes to identify and recognize school champions (SC Governor's Council School Awards, DHEC All Health Team, SC Healthy School Awards).

Objective 14: By December 31, 2010, at least 100 schools will provide opportunities for students to be physically active on school property before and after school.

Strategies

1. Provide information, resource materials and training to schools on before and after school models for implementing physical activity clubs, intramural sports and extended use of school physical activity facilities.
2. Partner with after school providers such as SC After School Alliance, AFHK, SC Recreation and Parks Association, and the YMCA, to adopt policies that require the incorporation of physical activity as a portion of their programming.

Goal 2: Increase the percentage of South Carolinians who consume at least 5 servings of fruits and vegetables a day.

Objective 1: By July 31, 2007, at least 3 South Carolina communities will have newly operating Farmers' Markets.

Strategies

1. In collaboration with other state agencies, clarify certification process for Farmers' Markets.
2. Work across state agencies to make it easier to set up local Farmers' Markets.
3. Through focus groups or key informant interviews with community partners/coalitions, identify 3 communities for implementation.
4. Educate and distribute information to farmers, churches, schools, and businesses in identified communities.
5. Review certification process and investigate use of Clemson Extension agents as certifiers to increase the number of certifiers so that more farmers are able to sell produce directly to consumers.
6. Publicize certification program.
7. Set policy so that all farmers want to be certified to sell in Farmers' Markets.

Objective 2: By September 30, 2007, 25% more seniors will be participating in the Senior Farmers' Market voucher program.

Strategies

1. In collaboration with other state agencies, simplify application procedures and help farmers with applications to accept vouchers.
2. In collaboration with other state agencies, simplify application procedures and help seniors with applications for vouchers.
3. Work with community leaders to set up a system so that farmers can bring produce to community locations (such as housing authority neighborhoods, senior centers, and churches).
4. Work with community leaders and state agencies to set up a system of transportation from low-income neighborhoods to Farmers' Markets and community market locations.
5. Publicize the Senior Farmers' Market.

Objective 3: By September 30, 2007, 25% more WIC participants will be participating in the WIC Farmer's Market program.

Strategies

1. In collaboration with other state agencies, simplify application procedures and help farmers with applications to accept vouchers.
2. In collaboration with other state agencies, simplify application procedures and help WIC participants with applications for vouchers.
3. Work with community leaders to set up a system so that farmers can bring produce to community locations (such as housing authority neighborhoods, worksites, child care centers, schools, and churches).
4. Work with community leaders and state agencies to set up a system of transportation from low-income neighborhoods to Farmers' Markets and community market locations.
5. Publicize the WIC Farmers' Market program.

Objective 4: By July 31, 2007, at least 3 communities will establish delivery of fresh produce to various sites, such as child care centers, faith-based organizations, schools, worksites, and hospitals.

Strategies

1. In identified communities, promote the delivery of farm produce to child care centers, faith-based organizations, schools, worksites, and hospitals.

   Action Steps:

   - *Encourage collaboration between Department of Agriculture, State Department of Education, Department of Social Services, Department of Health and Environmental Control, Chamber of Commerce, and Hospital Association to help farmers bring produce directly to consumers.*
   - *Investigate the Department of Defense fresh buying program and opportunities for expansion into communities, especially in rural areas where access and transportation issues are barriers to purchasing healthy foods.*

2. Market and publicize the distribution program.

Objective 5: By July 31, 2007, at least 3 communities will establish delivery of fresh produce from local farmers to small grocers in the area.

Strategies

1. Build a coalition of small grocers, farmers, SC Department of Agriculture, and commodity boards to develop relationships of benefit to the farmers, grocers, and community.
2. In identified communities, discuss distribution plans for delivery of produce to grocers.
3. In identified communities, promote and publicize the "farm to small grocer" program.

Objective 6: By July 31, 2008, at least 3 communities will have a communication plan for consumers, including information on buying, storing, and using fresh fruits and vegetables.

Strategies

1. Identify or develop multi-lingual, multi-cultural tapes, videos, printed materials, and calendars to help consumers use fresh produce.
2. Identify or develop limited literacy materials suitable for families with limited resources.
3. Develop system to print and distribute available printed materials (Commodity Board, USDA, EFNEP, NCI, etc.) to consumers at markets.
4. Develop system to provide demonstrations at the markets on how to prepare fresh produce (chefs/ nutritionists at markets).
5. Work with local supermarkets to help communicate message of eating more fruits and vegetables and distribution of materials at their stores (print messages on bags, signs in stores, etc.).

Objective 7: By December 31, 2008, at least 3 school districts will participate in a social marketing campaign to encourage students to consume 2 or more fruit and vegetable (non-fried) servings during the school day.

Strategies

1. Provide training and resources for conducting an age appropriate social marketing campaign in schools, making eating F/V "cool".
2. Provide resources to school on ways improve the packaging of available fruits and vegetables, making servings more individualized (cups of F/V that they can take, rather than being served, or single serving packages),

Objective 8: By July 31, 2009, at least 100 schools will implement the Five-A-Day programs in schools.

Strategies

1. Provide training and share model programs to school personnel on the 5-A-Day campaign at the SCASA , School Nurses, SCAHPERD, Early Childhood and Elementary Education conferences.
2. Provide a one-day training to potential school health leaders through the SC Healthy Schools Leadership Institute.
3. Provide a 5 A Day training as part of the SC Healthy Schools Summer Institute.
4. Educate teachers on the variety of 5 A Day resources for use in the classroom.

Objective 9: By December 31, 2007, at least 25 school districts will receive training on policies and other strategies for increasing the availability and consumption of fruits and vegetables.

Strategies for School Meals

1. Disseminate "how to" strategies to increase fruit and vegetable options including menu suggestions to district school food service directors, managers and staff.
2. Provide training to Food Service Personnel on the importance of having more fruits and vegetable options available and provide strategies to increase these options using model meal programs and marketing these options to students, staff and parents.
3. Provide training and ideas to above groups on how schools can afford more fresh fruits and vegetables as part of the school meal (school gardens, farmers markets)
4. Provide training on implementing school community gardens to interested teachers/staff.

*Strategies for Other Foods and Beverages**

*Other Foods and Beverages refer to any food sold or served on school grounds outside of the USDA Reimbursable meal program.

1. Develop and disseminate model policies that increase the availability of fruits and vegetables (and 100% fruit and vegetable products) through all other food and beverage sales outlets.

   A. **Vending Machines**
   - Distribute policy that assures that vending machines are stocked with fruits and vegetables and 100% fruit and vegetable products.

   B. **A-La-Carte**
   - Distribute policy that assures that all fruit and vegetable components of the school meal are available to purchase as a-la-carte.

   C. **Concessions**
   - Distribute policy that assures that fruits and vegetables and 100% fruit and vegetable products are sold at concession stands.

2. Disseminate model programs that increase the availability of fruit and vegetable options for students. (This includes 100% F& V juice products)

   A. **Vending Machines**
   - Provide information about model vending programs that increase fruit and vegetable options while maintaining profit margins.
   - Provide information to Principals and District personnel on negotiating vending contracts that provide healthy choices, including fruit and vegetable options.

   B. **A-La-Carte**
   - Disseminate model school food service programs that increase fruit and vegetable options on a-la-carte offerings.

   C. **Concessions**
   - Distribute model guideline and suggestions for having F/V available at concession stands, school stores and other school sponsored events

D**. Fundraisers**

- Distribute ideas for selling fruits and vegetables as fundraisers to Principals, PTA/PTO and booster club leaders

E**. Parties**

- Distribute model guidelines and suggestions for having F/V available during parties and class rewards

Goal 3: Increase the percentage of South Carolina mothers who breastfeed for at least six months.

Objective 1: By July 31, 2010, at least 10 worksites in SC will promote and support breastfeeding practices in the workplace.

Strategies

1. Employers will be provided with education on ROI (return on investment) and health benefits of breastfeeding.
2. Facilities will support breastfeeding by providing a private area for mothers, and equipment, such as hospital grade breast pumps and refrigerators for storage of expressed breast milk.
3. A policy will be implemented to ensure that nursing mothers will be allotted the necessary breaks from work to express milk.
4. Employers will educate all employees on the benefits of sustained breastfeeding.

Objective 2: By July 31, 2009, at least 10 health care facilities in South Carolina will have a breastfeeding policy in place.

Strategies

1. Through collaboration with organizations such as the SC Breastfeeding Coalition, SC Primary Health Care Association, and the La Leche League, complete an assessment of breastfeeding policies in health care organizations in the state to establish baseline measurements of policy and environmental supports for breastfeeding.
2. Provide sample policy statements and examples of environmental supports for breastfeeding to health care organizations in the state.
3. Work with hospitals, maternity centers, physician offices, and clinics to reinforce guidelines from WHO/UNICEF (International Code on the Marketing of Breast Milk Substitutes) and work toward eliminating practices that discourage breastfeeding (such as visible signs of formula promotion and infant formula discharge packs).
4. Work with hospitals and maternity centers to adopt the “Ten Steps to Successful Breastfeeding.”

Objective 3: By July 31, 2008, at least 50 health care providers in South Carolina will provide education and counseling in support of breastfeeding.

Strategies

1. Identify breastfeeding "champions" to assist in educating peers about the importance of promoting and supporting breastfeeding.
2. Conduct trainings for health care providers and disseminate current, evidence-based information on the importance of breastfeeding and its benefit in reducing obesity and other chronic diseases.
3. Promote breastfeeding education as a routine component in professional education/curricula, including medical, nursing, nutrition, health education, and social work programs.
4. Develop and disseminate materials to educate health care providers about the need to promote and support breastfeeding efforts.
5. Develop and disseminate a listing of breastfeeding resources (such as local lactation consultants, breastfeeding peer counselors, and lay support groups) to health care providers for use in the promo tion and support of breastfeeding.

Action Step:

- *Inform and educate health care providers about the importance of referring mothers with breastfeeding questions, concerns, or problems to a specialized professional.*

6. Provide positive public messages in support of breastfeeding.

Goal 4: Increase the percentage of South Carolina children and adults who achieve and maintain a healthy weight

Objective 1: By July 31, 2008, at least 50 worksites in SC will promote healthy nutrition in the workplace.

Strategies

1. SCCOPE will ensure that employers have current, science-based nutrition information and resources.
2. Increase the number of worksites providing nutrition-related educational materials to employees, such as the 5 A Day program.
3. Increase the number of worksites providing access to nutrition counseling by a registered dietitian.

Objective 2: By July 31, 2008, at least 25 worksites will adopt healthy nutrition policies.

Strategies

1. SCCOPE Workgroup on Business and Industry will develop and disseminate a *Nutrition in the Workplace Policy Guide*.
2. Employers and agencies will provide opportunities for employees to provide feedback on healthy food policy development.
3. Provide healthy choices of food and drink (water, juice, yogurt, fruits, vegetables, salads, low fat foods) in vending machines, snack rooms, and/or cafeteria.
4. Provide healthy refreshments at worksite events, meetings, and conferences.
5. Require vendors/food service providers to visibly post nutrition information for all foods served and sold.
6. Employers, when feasible, will provide space and encourage employees to eat at a separate area away from their workstation.

Objective 3: By July 31, 2009, at least 15 worksites in SC will participate in and promote healthy weight initiatives to include environmental and policy change.

Strategies

1. Form a collaborative group comprised of South Carolina business and industry professionals, employees, and health professionals to advise and consult with SC employers on productivity and health.
2. Identify champions in the business and industry setting to provide peer education on the ROI of programs addressing nutrition, physical activity, and breastfeeding.
3. Increase the number of SC employers with a wellness council or committee responsible for worksite wellness.
4. Provide training for such individuals or groups, for example, at the SCCPPA 2006 fall conference.

Objective 4: By July 31, 2010, at least 15 worksites in SC will provide and support on-site healthy weight-related activities and initiatives.

Strategies

1. Employers will request, from insurers, weight-related benefit/cost and utilization data for their employee population.
2. Employers will perform a healthy weight policy and environmental assessment of their worksite.
3. Employers will provide access to wellness counseling services to include nutrition, breastfeeding, weight loss, physical activity, and stress management.
4. Employers will offer health risk appraisals and provide targeted interventions to those with a BMI of 25 or greater.
5. Employers will provide incentives for those employees participating in a disease prevention program or disease management program containing a healthy weight component.
6. Employers will provide incentives for those employees who document the attainment of established and significant weight reduction goals or who are at a healthy BMI.
7. The business community will help develop and support the delivery of messages concerning overweight, obesity, and productivity on radio, TV, and elsewhere.
8. SCCOPE will create a Healthy Worksite Award Program to include recognition and incentives for businesses exhibiting leadership in healthy weight-related policies and programs.
9. Designate a week or month, sponsored by the State or by SCCOPE, which challenges employers to communicate healthy weight initiatives to their employees and community (Employee Health and Fitness Day).

Objective 5: By December 31, 2008, at least 3 communities in SC will have effective healthy dining programs.

Strategies

1. Through processes such as focus groups or key informant interviews with community partners/ coalitions, select communities to participate in a healthy dining program.
2. Identify model dining programs, such as *NC's Winner's Circle; Eat Smart! Ontario's Healthy Restaurant Program; and Maine's Diner's Choice*, that would be appropriate for use in SC.
3. Work with professional restaurant industry groups to identify incentive options for participating restaurants, such as a healthy dining certificate/award similar to inspection ratings, or recognition through local media, local restaurant reviews, etc.
4. Develop the healthy dining program. Criteria examples may include:

- Healthy menu options for children;
- Nutrient analysis of menu items (calories, carbohydrates, saturated fat, trans fat, protein);
- Trained wait staff on assisting customers with healthy selections;
- Half portion sizes available as menu options;
- Trained chefs on incorporating healthy foods;
- Increased fruit and vegetable options available.

5. Develop a plan for implementation and evaluation of the program.
6. Work with media, community leaders, DHEC, and restaurants in communities to advertise the program and encourage participation.
7. Implement the healthy dining program.
8. Evaluate the program.

Objective 6: By July 31, 2007, at least three 4-H youth programs or camps will pilot food, fitness and health programs.

Strategies

1. Through collaboration with Clemson Extension, identify three 4-H youth programs or camps for pilot programs.
2. Work with 4-H parents, leaders, and youth to identify ways to increase healthy eating and physical activity options available in programs.
3. Explore alternative low cost options so that youth sites can obtain healthy food alternatives.

Action Steps:

- *Develop cooperatives for buying products for programs.*
- *Explore Department of Defense fruit and vegetable program (possibly link with purchases for military bases).*
- *Determine if youth programs can participate in DSS summer food program and/or after school food program; work with DSS on ways to make application process easier.*

4. Ensure that foods served in the pilot youth programs follow 2005 Dietary Guidelines.
5. Demonstrate that children will eat the healthy foods and that costs can be contained.
6. Encourage older youth to do community projects (such as 4-H pinnacle projects), which encourage other youth and younger children to enjoy more fruits and vegetables and be more physically active (farm projects, garden projects, shopping and cooking projects).
7. Evaluate program efforts.

Objective 7: By July 31, 2010, at least 25 youth programs or camps across the state will offer healthy food choices.

Strategies

1. Investigate youth programs such as Boy and Girl Scouts, Boys and Girls Clubs, YMCA, and faith-based programs to identify foods served at youth programs and identify food-related activities.
2. Bring together partnership of parents, youth workers, school leaders, and youth group funders for update on results of pilot programs at 4-H camps and discussion on ways to expand program statewide.
3. Identify and advertise clear, consistent messages (more fruits and vegetables and healthy foods) in youth- and youth group-specific educational and promotion materials.
4. Develop and distribute a new *"Guide for Food to be Served at Youth Programs and Camps"* based on the 2005 Dietary Guidelines.

5. Work with youth organizations to add training modules related to healthy weight, foods served, physical activity, and reducing TV/screen time to existing trainings.
6. Encourage older youth to do community projects (Eagle service projects, badges, 4-H pinnacle projects, etc.) that encourage other youth and younger children to enjoy more fruits and vegetables (farm projects, garden projects, shopping and cooking projects).
7. Explore alternative low-cost options so that youth sites can obtain and sustain healthy food alternatives.

Action Steps:

- *Develop cooperatives for buying products for programs.*
- I*dentify and widely distribute lists of healthy foods and beverages that are inexpensive, easy to prepare, easy for children to eat, taste good, are easy to store, and have a long shelf-life.*
- *Encourage potential participation in DSS summer food program and/or after school food program.*

Objective 8: By July 31, 2006, increase by 20% the percentage of child care centers in the state implementing the *Color Me Healthy* curriculum.

Strategies

1. Increase the number of participants who complete the Color Me Healthy "train the trainer" workshop.
2. Increase the number of Color Me Healthy trainings provided to child care centers.
3. Inform and educate parents/caregivers about the importance of nutrition and physical activity programs for preschoolers.
4. Publicize to child care centers that the Color Me Healthy training has been approved for 4 hours of continuing education through the South Carolina Child Care Training System.
5. The Color Me Healthy State Trainer will present program updates at the annual meeting of the South Carolina Early Childhood Association and other statewide, regional, and local meetings.

Objective 9: By July 31, 2010, at least 25 child care centers in SC will implement the expanded Color Me Healthy curriculum.

Strategies

1. Expand the *Color Me Healthy* curriculum to include impact and process evaluation measures.

   Action Steps

- *Investigate examples of pertinent surveys to identify variables to measure.*
- *DOPC will take the lead on the development of evaluation measures, monitoring the impact of the curriculum on children, parents/caregivers, and child care providers.*

2. Expand the *Color Me Healthy* curriculum to include additional components, such as reducing TV/screen time, enhancing family/parental involvement, and enhancing policy and environmental supports.

   Action steps

- *Identify models and resources for child care centers to assist in development of expanded curriculum.*
- *Collaborate with Clemson Extension and the "Cooking with a Chef" program to provide food/cooking demonstrations and nutrition education as part of the enhanced curriculum components.*

3. Increase the number of participants who complete the Color Me Healthy "train the trainer" workshop.
4. Increase the number of trainings provided to child care centers throughout the state.
5. Inform and educate parents/caregivers about the importance of nutrition and physical activity programs for preschoolers.
6. Establish a "Healthy Child Care Center Award" program for centers effectively implementing the curriculum.

Objective 10: By July 31, 2008, 50 SC faith-based settings will have policies in place and offer formal or informal programs that support healthy eating and physical activity.

Strategies

1. Identify churches that have already established "healthy foods at church" policies.
2. Identify existing on-going educational programs and workshops available at faith-based settings that help adults and children improve eating habits and increase physical activity.
3. Develop and conduct 6 training workshops for health and faith leaders (congregational nurses, health ministers, other interested congregants) on how to introduce and sustain healthy eating and physical activity policies and programs at their churches.
4. Identify, obtain permissions, and duplicate program resources for use at the workshops, including examples of policies, practices, and program curricula already in use in other faith-based settings.
5. Establish and maintain a health and faith resources website with links to *Search Your Heart, Body and Soul, Health-e-AME Physical-e-Fit* program and other programs and materials, and links to other websites for information on obesity and health, such as CDC sites, 5-A-Day, WIN, and NHLBI sites.
6. Pilot the development of policies and programs to help members improve eating habits and increase physical activity at 10 additional SC churches.

Action Steps

- *Survey SC churches to find out if churches have healthy food and activity policies and programs, the details about the policies and programs, and whether they have any information on program outcomes.*

- *Develop working groups of church members and pastors at 10 interested churches to develop recommendations that encourage healthy meal and food choices at church events and more physical activity. Examples of activities these groups might consider:*

    - Establish a church vegetable garden
    - Support bringing farmer's market to churches on regular schedule
    - Have recipe contests / develop a collection of winning recipes for reduced fat salads, vegetables, soups, fruit desserts, one-dish meals for church suppers.
    - Establish recommendations for foods to serve at church events. Duplicate recipes from contest.
    - Encourage church members to form walking groups. Post group mileage in prominent place in church.

Objective 11: By July 31, 2007, at least 100 congregational pastors, ministers, and other leaders in the faith based setting will receive information and assistance regarding promoting and supporting faith and health messages, policies and programs.

Strategies

1. Convene group of spiritual leaders interested in bringing a model faith and health curriculum to one seminary in SC.
2. Determine if there are any faith and health programs or curricula in use in SC seminaries.
3. Select a faith and health curricula for use / dissemination. (from other states if not already in SC)
4. Identify speakers/ champions/ leaders; incorporate segments on faith and health into conference agendas to build support and interest.
5. Help spiritual leaders identify and support appropriate groups in their churches who can lead faith and health programs, such as: congregational / parish nurses, health educators, lay health coordinators, lay health promoters, youth health 'promoters'.

Objective 12: By December 31, 2010, at least 75 health care providers will follow national guidelines and standard protocols for weight management and the treatment of obesity.

Strategies

1. Collaborate with leadership of SC medical schools and other health care professional programs to include the prevention and treatment of obesity as a module in the curriculum.
2. Educate health care providers about the importance of healthy weight maintenance and prevention of overweight and obesity across the lifespan.

Action Steps:

- *Distribute NHLBI Clinical Guidelines.*
- *Conduct trainings on assessment of overweight and obesity using BMI and BMI-for-age.*

3. Promote self-study modules on healthy weight/weight management, which will include appropriate counseling and behavior change theory.

Action Step:

- *Educate health care professionals on patient self-management models using examples such as the Chronic Care Model.*

4. Provide resources to health care providers to assist with referrals for healthy weight maintenance.

Action Steps:

- *Develop and maintain a website accessible to health care providers that includes information about weight management programs and patient education materials.*
- *Maintain a resource listing of health care professionals trained to provide weight management services, including physical activity and nutrition specialists.*
- *Initiate a statewide referral phone line accessible to health care providers for weight loss/ prevention programs.*

Objective 13: By July 31, 2007, at least 3 health care champions will assist with advocacy efforts in support of healthy weight management services.

Strategies

1. Identify health care providers interested in being advocates for healthy weight management efforts throughout the state.
2. Advocate for the state legislature to establish policies for insurance coverage of weight management services by registered dietitians, social workers, psychologists, health educators, and other health professionals.
3. Collaborate with insurance regulators and insurance companies to enhance advocacy for initiatives and policies that support breastfeeding, healthful eating habits, physical activity, and healthy weight maintenance.
4. Champions to encourage peers to offer weight management programs at physician offices, managed-care settings, and health departments.

Objective 14: By December 31, 2008, at least 100 schools will implement proven, effective nutrition and physical activity curricula.

Strategies

1. Provide training to schools on proven, effective nutrition and physical activity curricula (*Planet Health*, *Eat Well, Keep Moving* and *Color Me Healthy*).

   Action Items

   - *Provide Train the Trainer programs in school districts and regions*
   - *Trainers provide training on curricula to teachers*
   - *Teachers implement curricula in schools.*
   - *Evaluate and follow up to determine implementation and technical assistance needs.*

Objective 15: By December 31, 2008, at least 25 % of students will consume three or more servings of calcium rich low fat dairy daily.

Strategies

1. Partner with AFHK.
2. Partner with milk bottlers to improve the packaging of 1% or less milk making it more appealing to students.

Objective 16: By December 31, 2008, at least 70% of students will report eating breakfast.

Strategies

1. Provide parent and student education regarding the importance of breakfast.
2. Provide information and technical assistance to school food service personnel and principals on alternative breakfast delivery strategies such as breakfast in the classroom, grab and go stations and the Universal Breakfast Program.
3. Provide marketing strategies to schools to promote eating breakfast.

Objective 17: By December 31, 2009, at least 300 schools will adopt the *SDE Task Force Recommendations for Improving Student Nutrition and Physical Activity.*

Strategies

1. Provide all school principals with a copy of the SDE Task Force Recommendations.
2. Develop a rating system to award schools that have implemented the recommendations.
3. Adopt state level policy that establishes nutrition and physical activity standards for k-12. Refer to the *SDE Task Force on Improving Student Nutrition and Physical Activity* and work with the Legislature or the State Board of Education.

Objective 18: By December 31, 2008, at least 150 schools will provide education and awareness to students and parents on the importance of achieving and maintaining a healthy weight.

Strategies

1. Include BMI fields in the SASSI reporting system.
2. Educate school nurses and PE teachers on how to measure BMI and record in SASSI.
3. Develop a local resource and referral list to give to families of students who are overweight.
4. SDE, in conjunction with partners will develop suggested procedures for schools regarding communication of BMI and suggestions for reaching and maintaining a healthy weight to students and parents.

Goal 5: Decrease the burden of obesity and obesity-related chronic diseases.

Objective 1: By July 31, 2007, at least 200 health care providers will be trained on the health and economic implications of obesity and obesity-related chronic diseases.

Strategies

1. In collaboration with DHEC chronic disease program areas, state and community coalitions/alliances, educate health care providers on the health implications of obesity and obesity-related chronic diseases.

   Action Steps:
   - *DOPC will collaborate with DHEC chronic disease program areas and state and community coalitions/alliances to incorporate education on the burden of obesity during health care provider trainings.*
   - *Collaborate with ORS and health economists to obtain data on the economic costs of obesity for trainings for health care providers.*

Objective 2: By December 31, 2008, at least 50 policy and decision makers will be provided training on the burden of obesity and obesity-related chronic diseases.

Strategies

1. Educate health care plan policy makers and purchasers of health care plans regarding the cost of overweight and obesity to the health care system.
2. Educate policy makers on the economic benefit of initiatives and policies that support healthful eating habits, physical activity, and healthy weight maintenance for treatment of obesity-related chronic diseases.

Goal 6: Increase the number of research projects in South Carolina related to obesity prevention and control.

Objective 1: By December 31, 2010, collaborate with the South Carolina Nutrition Research Consortium (SCNRC) on at least 3 research efforts dealing with obesity in the state.

Strategies

1. At least one member of the South Carolina Nutrition Research Consortium will serve as an Advisory Council member for SCCOPE.
2. DOPC will correspond at least monthly with the Nutrition Research Consortium contact to maintain communication on potential research opportunities.
3. SCCOPE will use research results to implement proven effective state-wide obesity related activities.

Objective 2: By December 31, 2009, DOPC will have provided ongoing updates to partners on potential obesity related research opportunities for the state.

Strategies

1. Establish and maintain a clearinghouse for obesity research opportunities.
2. Provide technical assistance on grant writing and community based participatory research to community partners and grass roots organizations.

Objective 3. By July 31, 2010, SCCOPE through its partners, will have obtained at least 5 obesity related research grants for the state.

Strategies

1. Within SCCOPE, form a research and grant writing subcommittee to lead the SCCOPE research efforts.
2. DOPC will identify individuals within DHEC who are interested and skilled in research activities.

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Glossary:

Body Mass Index (BMI) BMI is an indicator of body size based on height and weight. It is calculated as weight in kilograms divided by height in meters squared. The standard adult categories are underweight (BMI less than 18.5 kg/m2), normal (18.5 – 24.9 kg/m2), overweight (25 – 29.9 kg/m2), and obese (30 or more). For children (ages 2-20), a BMI below the 5th percentile for age and gender is underweight; between the 85th and 95th percentile is at risk for overweight; at or above the 95th percentile is overweight.

$$\text{Formula: BMI} = \frac{\text{Weight (kg)}}{\text{Height (m)2}} \left\{ \frac{\text{Weight in Pounds}}{(\text{Height in inches}) \times (\text{Height in inches})} \times 703 \right\}$$

Behavioral Risk Factor Surveillance System (BRFSS) is a major source of data, is a telephone survey conducted by all state health departments, the District of Columbia, Puerto Rico, the Virgin Islands, and Guam with assistance from CDC. BRFSS is the largest continuously conducted telephone health survey in the world, monitoring preventable chronic diseases, injuries, and infectious diseases. States use BRFSS data to track health problems and to develop and evaluate public health programs. Data are collected by using standard procedures through monthly telephone interviews with adults aged >18 years.

Capacity Building is a process to enhance the ability of a group or institution to manage change, resolve conflict, enhance coordination, foster communication, and ensure that data and information are shared.

Community Based Participatory Research is a collaborative process of research involving researchers and community representatives. It engages community members, employs local knowledge in the understanding of health problems and the design of interventions, and invests community members in the processes and products of research.

Guide to Community Preventive Services (Community Guide):
In developing the Guide to Community Preventive Services (Community Guide), the Task Force on Community Preventive Services uses a variety of both qualitative and quantitative factors to assess the strength of evidence for population-based interventions to promote health and prevent disease.

www.thecommunityguide.org

Strength of Evidence of Effectiveness	Task Force Recommendation
Strong	Strongly recommended
Sufficient	Recommended
Insufficient empirical information but supplemented by expert opinion	Recommended based on expert opinion
Available studies do not provide sufficient evidence	Insufficient evidence to determine effectiveness
Sufficient or strong evidence of ineffectiveness or harm	Discouraged

Evidence Based Practices are critical to expanding the knowledge base of what is or is not effective in addressing obesity and obesity-related chronic diseases.

Impact Evaluation is a systematic way of identifying if a program was responsible, in whole or in part, for causing the results, or if there are other factors that influenced the results.

Outcome Evaluation is a systematic way of evaluating if the actual outcomes or results of a program are consistent with the desired outcomes. Tools are used to assess if the program worked.

National Immunization Survey is sponsored by the Centers for Disease Control and Prevention for children between the ages of 19 and 35 months living in the United States at the time of the interview.

Pediatric Nutrition Surveillance System (PedNSS) is a program-based surveillance system that monitors the nutritional status of low-income infants, children, and women in federally funded maternal and child health programs.

Process Evaluation methods are used to document program implementation in order to monitor program fidelity and quality.

Promising Practices is a commitment to use the best evidence currently available to guide initial recommendations, and at the same time, develop a structure that is sufficiently flexible to incorporate new information.

Social Ecological Model (SEM) is a model that depicts how multiple factors influence (either positively or negatively) the health behavior of an individual**.** At the center of the model is the **i**ndividual. At this level, we consider the internal determinants of behavior, such as knowledge, attitudes, beliefs, and skills. This is the foundational level, but the model recognizes that many external forces (interpersonal, organizational, community, and society) influence these individual determinants. In order to facilitate behavior change it is important to address these external forces.

Social Marketing is the application of advertising and marketing principles and techniques to health or social issues with the intent of bringing about behavior change. The social marketing approaches used to reduce the barriers to and increase the benefits associated with the adoption of a new idea or practice within a selected population.

South Carolina Coalition for Obesity Prevention Efforts (SCCOPE) is a diverse group of partners, consisting of representatives from state government agencies, businesses, academia, faith-based organizations, health care organizations, and community-based groups, working together to promote healthy lifestyles and healthy communities.

Waist Circumference measurement is a tool to assess abdominal obesity, which is an independent risk factor for diseases.

Women, Infants, and Children (WIC) program serves to safeguard the health of low-income women, infants, & children up to age 5 who are at nutritional risk by providing nutritious foods to supplement diets, information on healthy eating, and referrals to health care.

Youth Risk Behavior Surveillance System (YRBS) monitors priority health risk behaviors that contribute markedly to the leading causes of death, disability and social problems among youth and adults in the United States. These behaviors, often established during childhood and early adolescence, include tobacco use, unhealthy dietary behaviors, inadequate physical activity, alcohol and other drug use, risky sexual behaviors that contribute to unintentional injuries and violence. Conducted as school-based survey every 2 years, YRBSS includes national, state, and local representative samples of students in grades 9 – 12. For states that do not participate in YRBSS, the Youth Tobacco Survey (YTS) can provide data on the prevalence of tobacco use among high school students.

Goals Data

1. Increase the percentage of South Carolina children and adults who meet the current age specific recommendations for regular physical activity.

* Adults should engage in moderate-intensity physical activities for at least 30 minutes on 5 or more days of the week.
* Adults should engage in vigorous-intensity physical activity 3 or more days per week for 20 or more minutes per occasion.

Adults (2003 BRFSS)

- **Meets recommendations for regular physical activity**
  - ⇒ Total
    - 46.2% of South Carolinians meet recommendations for regular physical activity.
  - ⇒ By race
    - 48.9% of Caucasians in SC meet recommendations for regular physical activity
    - 37.1% of African-Americans in SC meet recommendations for regular physical activity
    - 42.9% of Hispanics in SC meet recommendations for regular physical activity
  - ⇒ By gender
    - 50.1% of males in SC meet recommendations for regular physical activity
    - 42.6% of females in SC meet recommendation for regular physical activity

- **Classified as Physically Inactive**
  - ⇒ Total
    - 14.8% of South Carolinians are classified as physically inactive
  - ⇒ By race
    - 11.8% of Caucasians in SC are classified as physically inactive
    - 22.5% of African-Americans in SC are classified as physically inactive
    - 19.9% of Hispanics in SC are classified as physically inactive
  - ⇒ By gender
    - 13.4% of males in SC are classified as physically inactive
    - 16.2% of females in SC are classified as physically inactive

High Schoolers (1999 YRBS)

- **Meets recommendations for regular physical activity**
  - ⇒ Total
    - 60.0% of SC high schoolers meet recommendations for regular physical activity.
  - ⇒ By race
    - 66.4% of high school age Caucasians in SC meet recommendations for regular physical activity
    - 52.9% of high school age African-Americans in SC meet recommendations for regular physical activity
    - 60.9% of high school age Hispanics in SC meet recommendations for regular physical activity
  - ⇒ By gender
    - 66.1% of high school age males in SC meet recommendations for regular physical activity
    - 54.0% of high school age females in SC meet recommendation for regular physical activity

2. Increase the percentage of South Carolina children and adults who consume at least five servings of fruits and vegetables a day.

Adults (2003 BRFSS)

- **Consume at least 5 servings of fruits and vegetables a day**
  - ⇒ Total
    - 22.3% of South Carolinians consume at least 5 servings of fruits and vegetables a day
  - ⇒ By race
    - 22.7% of Caucasians in SC consume at least 5 servings of fruits and vegetables a day
    - 19.5% of African-Americans in SC consume at least 5 servings of fruits and vegetables a day
    - 27.8% of Hispanics in SC consume at least 5 servings of fruits and vegetables a day
  - ⇒ By gender
    - 18% of males in SC consume at least 5 servings of fruits and vegetables a day
    - 26.2% of females in SC consume at least 5 servings of fruits and vegetables a day

High Schoolers (1999 YRBS)

- **Consume at least 5 servings of fruits and vegetables a day**
  - ⇒ Total
    - 17.6% of SC high schoolers consume at least 5 servings of fruits and vegetables a day
  - ⇒ By race
    - 13.9% of high school age Caucasians in SC consume at least 5 servings of fruits and vegetables a day
    - 20.6% of high school age African-Americans in SC consume at least 5 servings of fruits and vegetables a day
    - 20% of high school age Hispanics in SC consume at least 5 servings of fruits and vegetables a day
  - ⇒ By gender
    - 18.3% of high school age males in SC consume at least 5 servings of fruits and vegetables a day
    - 17% of high school age females in SC consume at least 5 servings of fruits and vegetables a day

3. Increase the percentage of South Carolina mothers who breastfeed for at least six months.

Mothers (2003 National Immunization Survey)

- **Breastfeed for at least 6 months**

  ⇒ Total
  - 27.3% of SC mothers breastfeed for at least 6 months
  - 3.6% of SC mothers exclusively breastfeed for at least 6 months

4. Increase the percentage of South Carolina children and adults who achieve and maintain a healthy weight.

Adults (2003 BRFSS)

- **Achieve and maintain a healthy weight (RECOMMENDED RANGE)**

  ⇒ Total
  - 37.5% of South Carolinians are within the recommended range for healthy weight based on BMI

  ⇒ By race
  - 41.9% of Caucasians in SC are within the recommended range for healthy weight based on BMI
  - 26.6% of African-Americans in SC are within the recommended range for healthy weight based on BMI
  - 26.6% of Hispanics in SC are within the recommended range for healthy weight based on BMI

  ⇒ By gender
  - 31.9% of males in SC are within the recommended range for healthy weight based on BMI
  - 42.9% of females in SC are within the recommended range for healthy weight based on BMI

- **Achieve and maintain a healthy weight (OVERWEIGHT)**

  ⇒ Total
  - 35.8% of South Carolinians are overweight based on BMI

  ⇒ By race
  - 35.4% of Caucasians in SC are overweight based on BMI
  - 34.5% of African-Americans in SC are overweight based on BMI
  - 37.9% of Hispanics in SC are overweight based on BMI

  ⇒ By gender
  - 43.6% of males in SC are overweight based on BMI
  - 28.3% of females in SC are overweight based on BMI

- **Achieve and maintain a healthy weight (OBESE)**
  - ⇒ Total
    - 24.5% of South Carolinians are obese based on BMI
  - ⇒ By race
    - 20.4% of Caucasians in SC are obese based on BMI
    - 37.8% of African-Americans in SC are obese based on BMI
    - i24.9% of Hispanics in SC are obese based on BMI
  - ⇒ By gender
    - 23.2% of males in SC are obese based on BMI
    - 25.6 of females in SC are obese based on BMI

- **Achieve and maintain a healthy weight (Intent)**
  - ⇒ Total
    - 39.3% of South Carolinians have tried to lose weight in the last year
  - ⇒ By race
    - 8.1% of Caucasians in SC have tried to lose weight in the last year
    - 44% of African-Americans in SC have tried to lose weight in the last year
    - 43.4% of Hispanics in SC have tried to lose weight in the last year
  - ⇒ By gender
    - 31.5% of males in SC have tried to lose weight in the last year
    - 46.5% of females in SC have tried to lose weight in the last year

High Schoolers (1999 YRBS)

- **Achieve and maintain a healthy weight (OVERWEIGHT)**
  - ⇒ Total
    - 11.7% of SC high schoolers are overweight based on BMI
  - ⇒ By race
    - 9.1% of high school age Caucasians in SC are overweight based on BMI
    - 15.1% of high school age African-Americans in SC are overweight based on BMI
    - 0.4% of high school age Hispanics in SC are overweight based on BMI
  - ⇒ By gender
    - 14.6% of high school age males in SC are overweight based on BMI
    - 8.9% of high school age females in SC are overweight based on BMI

- **Achieve and maintain a healthy weight (AT RISK FOR OVERWEIGHT)**
  - ⇒ Total
    - 12.9% of SC high schoolers are at risk for becoming overweight based on BMI
  - ⇒ By race
    - 10.3% of high school age Caucasians in SC are at risk for becoming overweight based on BMI
    - 15.4% of high school age African-Americans in SC are at risk for becoming overweight based on BMI
    - 17.3% of high school age Hispanics in SC are at risk for becoming overweight based on BMI
  - ⇒ By gender
    - 13.3% of high school age males in SC are at risk for becoming overweight based on BMI
    - 12.4% of high school age females in SC are at risk for becoming overweight based on BMI

- **Achieve and maintain a healthy weight (Intent)**
  - ⇒ Total
    - 39.8% of SC high schoolers have tried to lose weight in the last year
  - ⇒ By race
    - 41.9% of high school age Caucasians in SC have tried to lose weight in the last year
    - 37.3% of high school age African-Americans in SC have tried to lose weight in the last year
    - 46% of high school age Hispanics in SC have tried to lose weight in the last year
  - ⇒ By gender
    - 25.7% of high school age males in SC have tried to lose weight in the last year
    - 53.7% of high school age females in SC have tried to lose weight in the last year

High Schoolers (1999 YRBS)

- **Watch two or fewer hours of television per day.**
  - ⇒ Total
    - 52.5% of SC high schoolers watch two or fewer hours of television per day
  - ⇒ By race
    - 66.6% of high school age Caucasians in SC watch two or fewer hours of television per day
    - 35.4% of high school age African-Americans in SC watch two or fewer hours of television per day
    - 53.8% of high school age Hispanics in SC watch two or fewer hours of television per day
  - ⇒ By gender
    - 53% of high school age males in SC watch two or fewer hours of television per day
    - 51.9% of high school age females in SC watch two or fewer hours of television per day

5. Decrease the burden of obesity-related chronic disease.

Quality of Life Impact:
A significant percentage of obese individuals do not rate their general health as excellent or very good as compared to those with lower BMI. Obese individuals in the state also report a significantly higher average of physical or mental health days that were "Not Good" as compared to those with a lower BMI.

Economic Impact:
In 2003, obesity-attributable medical expenditures in SC totaled $1.06 billion.

Obesity-Related Chronic Diseases:
DHEC Office of Chronic Disease Epidemiology is developing attributable risk calculations for obesity on the following diseases: CHD, Stroke, Diabetes, Cancer, and Arthritis. When calculated, health expenditures related to obesity can also be analyzed in greater detail.

6. Increase the number of research projects in South Carolina related to obesity prevention and control.

No baseline currently exists that captures this information on a statewide level.

Resources

www.nhlbi.nih.gov/guidelines/obesity/practgde.htm
Practical Guide to the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults

http://www.ama-assn.org/ama/pub/category/10931.html
American Medical Association: Assessment and Management of Adult Obesity

http://www.cdc.gov/nccdphp/dnpa/growthcharts/training.htm
BMI for age Growth Chart Modules

http://www.acsm-msse.org/pt/pt-core/template-journal/msse/media/1201.pdf
American College of Sports Medicine's Position Stand on Appropriate Interventions for Weight loss and Prevention of Weight Regain for Adults

Patient Centered Assessment and Counseling for Exercise and Nutrition

http://aappolicy.aappublications.org/cgi/content/full/pediatrics;112/2/424
American Academy of Pediatrics
Policy Statement on the Prevention of Pediatric Overweight and Obesity

http://aappolicy.aappublications.org/cgi/reprint/pediatrics;113/1/152.pdf
American Academy of Pediatrics
Policy Statement on Soft Drinks in Schools

http://pediatrics.aappublications.org/cgi/content/full/115/2/496
American Academy of Pediatrics
Updated Statement on Breastfeeding

http://www.obesity.org
American Obesity Association

http://www.cfah.org/pdfs/health_monograph.pdf
Health Behavior Change in Managed Care: A Status Report

www.surgeongeneral.gov/sgoffice.htm
Office of the Surgeon General

http://www.healthinschools.org/sh/obesityfs.pdf
Childhood Obesity Fact Sheet

www.nlm.nih.gov/medlineplus/obesity.html
National Library of Medicine Obesity Resources

www.cdc.gov/nccdphp/
CDC's Division of Chronic Disease Prevention and Health Promotion

http://www.mayoclinic.com/invoke.cfm?id=FL00058
Childhood obesity: Parenting advice

http://www.mayoclinic.com/invoke.cfm?id=FL00057
Sensible approaches to children's weight problems

www.healthysc.gov
Healthy South Carolina Challenge

www.eatright.org
American Dietetic Association

http://www.thecommunityguide.org/
Guide to Community Preventive Services

http://www.cspinet.org/nutritionpolicy/nana.html
National Alliance for Nutrition and Activity (Center for Science in the Public Interest)

odphp.osophs.dhhs.gov/
Office of Disease Prevention & Health Promotion

http://www.cdc.gov/nccdphp/promising_practices/
CDC's Promising Practices in Chronic Disease Prevention and Control: A Public Health Framework For Action

http://www.cdc.gov/phppo/pce/index.htm
A CDC document on principles for engaging the community.

ctb.lsi.ukans.edu/
Community Tool Box

http://www.healthpolicycoach.org
Health Policy Guide

http://www.prevent.org/publications/Physical_Activity_Roundtable_FINAL.pdf
Promoting Physical Activities in Communities: Forward Looking Options From An Executive Roundtable

www.usda.gov/cnpp
USDA's Center for Nutrition Policy and Promotion
Includes the Interactive Healthy Eating Index

www.cdc.gov/nccdphp/
CDC's Division of Chronic Disease Prevention and Health Promotion

www.usda.gov/fnic
Food and Nutrition Information Center

www.dole5aday.com
Dole Food Company

www.5aday.com
Produce for a Better Health Foundation

www.pma.com
Produce Marketing Association

http://www.4woman.gov/Breastfeeding/bluprntbk2.pdf
HHS Blueprint for Action on Breastfeeding

http://www.usbreastfeeding.org/
United States Breastfeeding Committee

http://www.unicef.org/newsline/tenstps.htm
WHO/UNICEF Ten Steps to Successful Breastfeeding

http://www.cdc.gov/breastfeeding/compend-babyfriendlywho.htm
Breastfeeding Friendly Hospital Program

http://www.ers.usda.gov/publications/fanrr13/
The Economic Benefits of Breastfeeding

http://www.who.int/nut/documents/code_english.PDF
International Code of Marketing Breast Milk Substitutes

http://www.preventioninstitute.org/pdf/CHI_breastfeeding.pdf
Promising Practices in Breastfeeding Promotion

http://www.dshs.state.tx.us/wichd/lactate/mother.shtm
Breastfeeding friendly worksite

http://www.usbreastfeeding.org/Issue-Papers/Checklist-WP-BF-Support.pdf
Worksite Breastfeeding Checklist

http://www.phppo.cdc.gov/documents/faithhealth.pdf
A CDC document on how to collaborate and engage faith-based communities around public health issues

http://www.health-e-ame.com/
AME Church Health/Wellness

http://www.prevent.org/publications/Healthy_Workforce_2010.pdf
Healthy Workforce 2010

http://www.welcoa.org/freeresources/
Free worksite resources and presentations from Welcoa

http://www.wbgh.com/
Washington Business Group on Health

http://www.phi.org/pdf-library/dhs-worksite.pdf
Fruits and Vegetables and Physical Activity at The Worksite: Business Leaders and Working Women Speak Out on Access and Environment

http://www.shapingamericasyouth.com/Default.aspx
Shaping America's Youth

www.cdc.gov/nccdphp/dash/SHI/index.htm
School Health Index

http://www.schoolwellnesspolicies.org/WellnessPolicies.html
Model School Wellness Policies

http://www.schoolnutrition.org/Index.aspx?id=1173
Model School Wellness Policies

www.cdc.gov/nccdphp/dash/nutguide.htm
CDC's Guidelines for School Health Programs to Promote Lifelong Healthy Eating

http://www.cdc.gov/nccdphp/dnpa/kidswalk/
Walk to School Day

http://www.bikewalk.org/ncbw_forum/livable1_8.pdf
Safe Routes to School

www.usda.gov/news/usdakids/index.html
USDA for Kids

www.sph.uth.tmc.edu/catch
Coordinated Approach to Child Health (CATCH)

http://www.rwjf.org/publications/publicationsPdfs/healthySchools.pdf
Healthy Schools for Healthy Kids

www.nasbe.org/HealthySchools/fithealthy.mgi
Fit, Healthy and Ready to Learn: A School Health Policy Guide

www.aahperd.org
American Association for Health, Physical Education, Recreation, and Dance

http://www.aahperd.org/naspe/template.cfm?template=pr_032504.html
National Physical Education Standards

http://www.aahperd.org/naspe/template.cfm?template=kids_brochure.html
Kids in Action: Activity Guide for Children Birth to Five Years of Age

http://www.aahperd.org/naspe/template.cfm?template=stats.html
Physical Education Statistics

http://www.aahperd.org/naspe/template.cfm?template=pr_123103.html
Summary of Physical Activity for Children: A Statement of Guidelines for Children Ages 5-12

www.cdc.gov/nccdphp/dash/nutguide.htm
CDC Guidelines for School Health Programs to Promote Lifelong Healthy Eating

www.fns.usda.gov/tn/Healthy/changing.html
Changing the Scene (School Nutrition)

http://kidshealth.org/research/health_report.html
Health Report Cards increase Parents' Awareness of Obesity/Overweight

http://www.eatsmartmovemorenc.com/tools.htm
Standards, fact sheets, tools and modules for school nutrition
Also contains a SyberShop module for ages 13-19

http://www.actionforhealthykids.org/
Action for Healthy Kids

http://www.eatsmartmovemorenc.com/colormehealthy/
Color Me Healthy Curriculum

http://www.hsph.harvard.edu/prc/proj_eat.html
Eat Well and Keep Moving – integrated elementary nutrition/pa curriculum

http://www.hsph.harvard.edu/prc/proj_planet.html
Planet Health – integrated upper elementary nutrition/pa curriculum

www.sph.uth.tmc.edu/catch
Coordinated Approach to Child Health (CATCH) – curriculum

http://www.sparkpe.org/index.jsp
PE (k-8) and afterschool curriculum

http://www.take10.net/whatistake10.asp?page=new
Take 10! physical activity program

http://www.creativewalking.com/school.html
Resources for school–based walking programs

http://www.cdc.gov/youthcampaign/
CDC's VERB campaign for physical activity

http://www.squaremeals.org/fn/home/page/0,1248,2348_0_0_0,00.html
Variety of tools for school nutrition from the TX Department of Agriculture

http://www.farmtoschool.org/
Farm to School Nutrition Program

http://cspinet.org/nutritionpolicy/policy_options.html#school_foods
PA & NU resources, vending options, fundraisers, F & V program in schools, class-room rewards, policies, revenue impact when improving school foods, strengthening NU ed, etc

http://nutrition.hhdev.psu.edu/projectpa/frames_html/frames_homepage.html
tools and resources for improving school nutrition

http://www.walkableamerica.org/
Partnership for a Walkable America

www.americaonthemove.org
America On the Move

http://www.activelivingbydesign.org/
Active Living By Design

www.sccppa.org
South Carolina Coalition for Promoting Physical Activity

http://www.bikewalk.org/
Pedestrian and Biking Information

http://www.cdc.gov/nccdphp/dnpa/physical/handbook/index.htm
The Physical Activity Evaluation Handbook

www.cdc.gov/nccdphp/dash/physact.htm
CDC's Guidelines for School and Community Programs to Promote Lifelong Physical Activity Among Young People

www.ncsl.org
National Council of State Legislatures

OVERWEIGHT IN SOUTH CAROLINA *Children*

The Problem

- Approximately **1 out 8** high school students in South Carolina is overweight.[1]*
- Over **25%** of low-income children ages 2-5 in South Carolina are overweight or at risk of overweight.[2]
- Nationally, overweight rates in children ages 6-11 have **tripled** since the late 1970s, while rates for adolescents ages 12-19 have **more than doubled** in the same time period.[3]
- Overweight adolescents have a **70%** chance of becoming overweight or obese adults.[4]
- Overweight children are at increased risk for high blood pressure, asthma, sleep apnea, diabetes, and decreased well-being.[4]
- If current trends continue, **1 out of every 3 children** born in 2000 will be diagnosed with type 2 diabetes, primarily due to a poor diet and lack of physical activity.[5]

[illegible]

Risk Factors

- **Less than 20%** of adolescents in South Carolina eat the recommended 5-9 servings of fruits and vegetables per day.[1]
- Nearly **50%** of adolescents in South Carolina do not meet the minimum recommendations for adequate physical activity.[1]
- In the US, children watch TV an average of 1,023 hours per year (compared to 900 hours per year spent in school).[9]
- Nationally, sweetened beverage consumption has **doubled** among youth in the last 30 years.[6]
- By the time children are 14 years or older, 32% of young women and 52% of young men are consuming **3 or more sugared soft drinks daily**.[7]
- South Carolina mothers rank **43rd out of all states** in breastfeeding rates (breastfeeding has been shown to reduce the risk of overweight in children).[8]

"We must…intensify efforts for early identification and prevention of overweight, or we are going to have the first generation of children who are not going to live as long as their parents."

Dr. George Blackburn
Harvard Medical School

Keys to Healthy Kids at a Healthy Weight

- Get at least 60 minutes of moderate to vigorous exercise every day.
- Eat at least 5 servings of fruits and vegetables every day.
- Drink 1% or less milk.
- New moms should breastfeed for at least 6 months.
- Limit foods and beverages with added sugars (soft drinks, soda, candy).
- Support school and local efforts to adopt policies supportive of good nutrition and active living.

Please see other side for information about healthy weight.

OVERWEIGHT IN SOUTH CAROLINA *Children*

Weight in Children

The term obesity is not used when describing children and youth. Instead, children and youth are said to be "at risk of overweight" or "overweight." This terminology is used because children and youth are growing and their weight may significantly change during the growth period. Because ideal weight for children and youth is dependent on age and gender (as well as height), adult BMI charts are not appropriate for children. BMI-for-age growth charts are used to determine a child's BMI percentile as compared to other children of the same age and gender. Categories of BMI for children and youth under 20 years of age are divided into the following percentiles:

Category	Percentile
Underweight	Less than 5th
Normal	5th to 84th
At risk of overweight	85th to 94th
Overweight	95th and higher

For example, a 10-year old boy with a BMI-for-age at the 90th percentile means that 90% of males of the same age and height have a lower BMI. This child would be considered overweight.

More information on the 2002 CDC Growth Charts can be found at ***http://www.cdc.gov/growthcharts***

1. *Youth Risk Behavior Surveillance Survey (YRBSS), 1999*
2. *Pediatric Nutrition Surveillance System (PedNSS), 2003*
3. *Centers for Disease Control, National Center for Health Statistics. (2000) NHANES IV short report*
4. *U.S. Department of Health and Human Services. The Surgeon General's call to action to prevent and decrease overweight and obesity. (Rockville, MD): U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General; (2001).*
5. *Vekhattilavayan, K. The Journal of the American Medical Association, Oct. 8, 2003; vol 290 : pp 1884-1890.*
6. *Gleason P and Suitor C. Children's diets in the mid-1990s: dietary intake and its relationship with school meal participation. USDA Report No.: CN-01-CD, (2001).*
7. *Bichon S and Popkin B. Changes in beverage intake between 1977 and 2001. American Journal of Preventive Medicine 2004;27(3)205-210.*
8. *National Immunization Survey, National Center for Health Statistics (NCHS), 2003. (Measure taken at 6 months after delivery). Obesity Research 12(1): 18-24 (January 2004).*
9. *Bichon Media Research, 2000*

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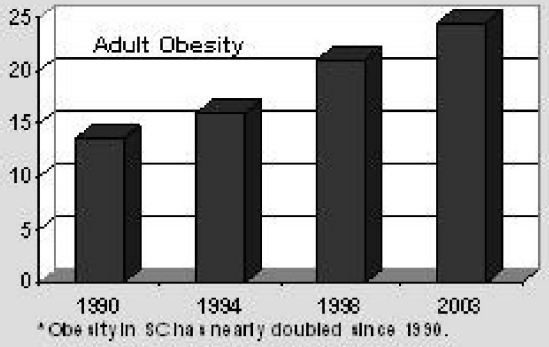
OVERWEIGHT IN SOUTH CAROLINA

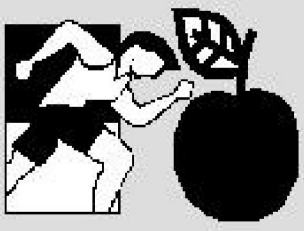
Obesity in SC

The Problem

- Obesity rates in South Carolina have nearly **doubled** since 1990. [1]
- In 2003, South Carolina had the **13th worst** obesity rate in the nation.
- **61%** of adults in South Carolina are either overweight or obese. (1)
- **25%** of adults in South Carolina are obese. [1]
- Obesity-related medical costs in South Carolina topped **$1 billion in 2003**. This translates to a cost of **$256 per South Carolinian**. [2]
- Of the $1 billion dollars spent on obesity-related medical costs in SC, **over half of these costs were through Medicaid/Medicare.** [2]
- Although obesity affects all populations, rates of obesity are higher among minorities and the underserved.
- South Carolina has one of the **highest rates** of obesity-related chronic disease such as heart disease, stroke, and diabetes in the nation.



* Obesity in SC has nearly doubled since 1990.



Factors Leading to Obesity

- Over **half** of South Carolinians are either totally inactive or do not get the recommended amount of physical activity. [1]
- Over **75%** of South Carolinians do not consume the recommended number of fruits and vegetables per day. [1]
- South Carolina mothers rank **48rd** out of all states in breastfeeding rates (breastfeeding has been shown to reduce the risk of obesity in children). [4]

Diseases Related to Obesity	
Heart Disease	**Diabetes**
High Blood Pressure	**Sleep Apnea**
High Cholesterol	**Depression**
Some Cancers	**Osteoarthritis**
Gall Bladder Disease	**Asthma**

What Can You Do?

- Become an advocate for policies supportive of active living, such as Safe Routes to School and Smart Growth initiatives.
- Be active for at least 30 minutes on most days of the week.
- Support policies and programs designed to increase access to healthy foods such as Farmer's Markets and adopting standards for all foods served in schools.
- Eat at least 5 servings of fruits and vegetables a day.
- Reduce portion sizes.
- Limit TV time to less than 2 hours a day.
- New mothers should breastfeed for at least six months.

Please see other side for information about healthy weight.

OVERWEIGHT IN SOUTH CAROLINA

Obesity in SC

What's the difference between overweight and obesity?

A BMI between 18.5 and 24.9 is considered normal weight for adults. A BMI from 25 and 29.9 is considered overweight, and a BMI of 30 or higher is considered obese. Obesity is further classified based on severity: BMI of 30 - 34.9 is Class 1, BMI of 35 – 39.9 is Class II Obesity, and Class III Obesity is a BMI over 40. Research has shown that as BMI rises into the more severe ranges (Class II and Class III), the risk for morbidity and mortality also increase.

BMI

The commonly accepted measure of being overweight and obesity in adults is the Body Mass Index, or BMI. In adults, the BMI measurement is determined by body weight relative to height. BMI is best used as a screening tool and not a diagnostic tool. Additionally, BMI is only one piece of a person's health profile, and other measures and risk factors (e.g., waist circumference, smoking, physical activity level, diet) should also be addressed.

Body **M**ass **I**ndex or BMI is a tool for indicating weight status in adults. It is a measure of weight for height. For adults *over 20 years old*, BMI falls into one of these categories:

BMI	Weight Status
Below 18.5	Underweight
18.5 – 24.9	Normal
25.0 – 29.9	Overweight
30.0 & above	Obese

Body Mass Index can be calculated using pounds and inches with this equation

$$\text{BMI} = \left(\frac{\text{Weight in Pounds}}{(\text{Height in inches}) \times (\text{Height in inches})} \right) \times 703$$

For example, a person who weighs 220 pounds and is 6 feet 3 inches tall has a BMI of 27.5.

$$\left(\frac{220 \text{ lbs.}}{(75 \text{ inches}) \times (75 \text{ inches})} \right) \times 703 = 27.5$$

1. *Behavioral Risk Factor Surveillance Survey (BRFSS), 2003.*
2. *Eric A. Finkelstein, Ian C. Fiebelkorn, and Guijing Wang. State-level estimates of annual medical expenditures attributable to obesity, Obesity Research 12(7):18-24 (January 2004).*
3. *National Vital Statistics Report (NVSR), 2001.*
4. *National Immunization Survey, National Center for Health Statistics (NCHS), 2003. (Measure taken at 6 months after delivery). Obesity Research 12(7): 18-24 (January 2004).*

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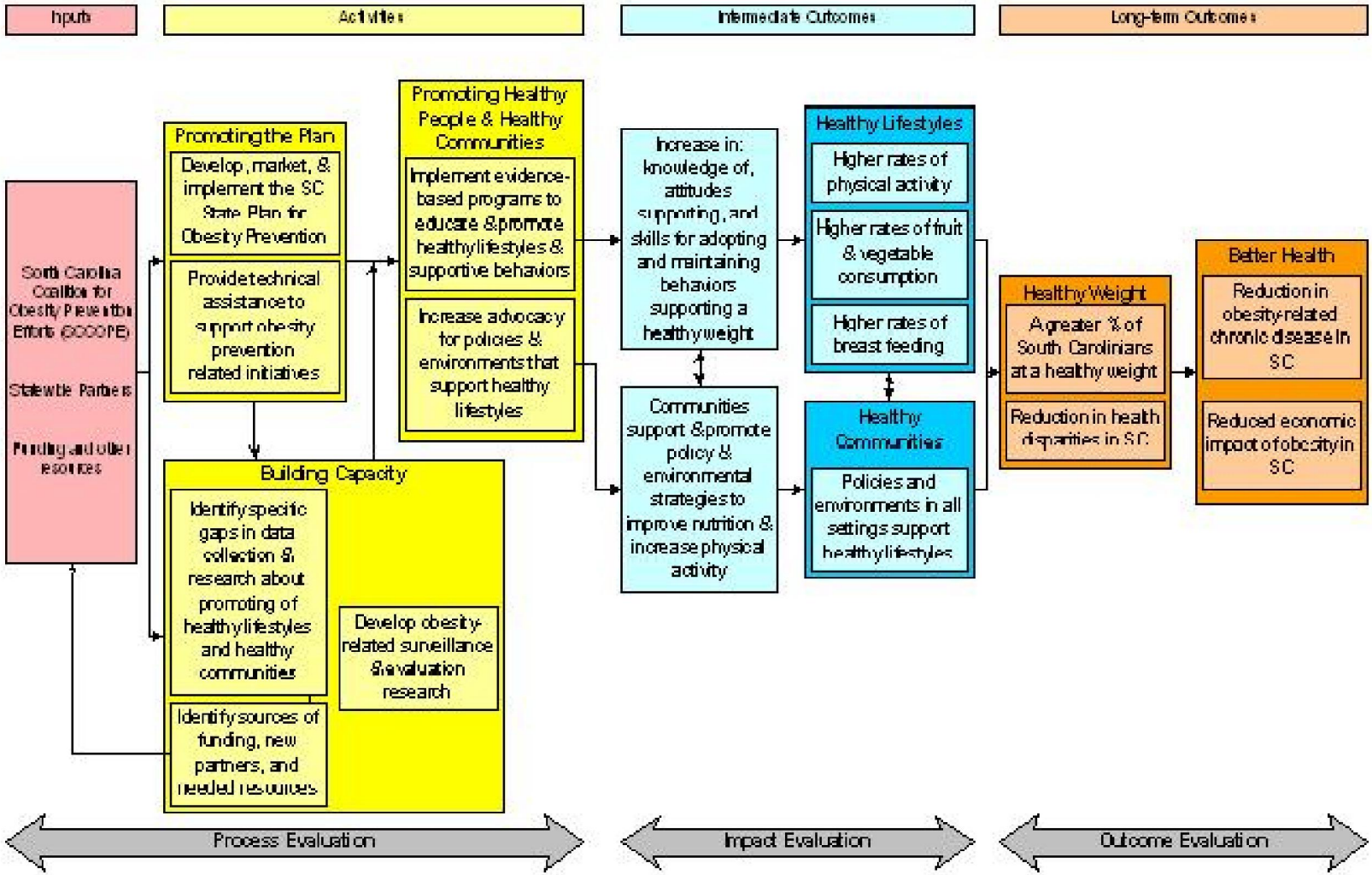
Moving South Carolina Toward a Healthy Weight

Promoting Healthy Lifestyles and Healthy Communities



The *Moving South Carolina Toward a Healthy Weight* Logic model was developed to illustrate the relationships between inputs, activities and outcomes associated with South Carolina's statewide plan to address obesity. This tool is intended to aid in describing the causal relationships between inputs and activities and how they are expected to lead to intermediate changes necessary in facilitating the attainment of specific goals outlined in *The State Plan* for obesity prevention.

Inputs

The first column of the logic model, Inputs, lists the work groups, partners and resources that provide infrastructure for obesity prevention and control efforts in South Carolina. SCCOPE Work Groups were charged with identifying and defining specific goals and objectives related to business and industry, community and faith-based organizations, school, and health care systems. These Work Groups will continue to provide guidance during implementation of the state plan. Of course, none of the efforts outlined in this document could be possible without CDC funding, in-kind support and other external funding/resources.

Activities

The second and third columns highlight the activities necessary for implementation of the state plan. These activities are sub-divided into promoting the plan, building capacity, and promoting healthy people and healthy communities,

Promoting the Plan. Marketing will involve distribution of the plan, a "kick off" at the state capital with speakers/partners promoting the plan, as well as plans to highlight specific obesity prevention and control efforts going on around the state. Another aspect of promoting the plan will involve providing ongoing technical support to statewide partners in obesity related efforts.

Milestone 1: The first few pages of this document describe three desired outcomes indicative of success in obesity prevention and control in SC. Inputs and plan promotion activities described above represent the first of those desired outcomes: *A comprehensive, coordinated statewide effort to promote healthy weight.*

Building Capacity. The Obesity Prevention and Control Program of DHEC and SCCOPE are committed to the identification of gaps in surveillance data related to obesity and identifying evidence based approaches for obesity prevention and control. In order to facilitate surveillance, research and evidence-based capacity, planning is underway to provide available funds and seek additional funding to aid the efforts of our current and new partners in obesity-related surveillance, research and program evaluation.

Promoting Healthy People and Healthy Communities. Promoting the Plan and building surveillance, research and program evaluation capacity is necessary in promoting the health of communities through data driven programs. Such evidence can bolster policy advocacy and environmental changes supportive of obesity prevention and control.

Note: Intermediate outcomes are also expected to interact with one another in a way that changes in one outcome may directly affect changes in another outcome.

Intermediate Outcomes

The fourth and fifth columns show expected intermediate outcomes resulting from proposed activities. Evidence-based obesity programs should result in increases in knowledge, attitudes, support, and skills (antecedents) necessary in adopting and maintaining behaviors associated with healthy weight. It is expected that increased policy advocacy and environmental changes (predisposing, enabling, and reinforcing factors) will support strategies to improve nutrition and increase physical activity.

Milestone 2: *Communities support and promote the adoption of policy and environmental strategies to improve nutrition and increase physical activity.*

Healthy Lifestyles. By addressing the antecedents of behavior change among individuals, groups and communities across SC, higher rates of physical activity, increased fruit and vegetable consumption, and a greater number of mothers breast feeding are expected.

Healthy Communities. Another intermediate outcome includes environmental and policy changes in all settings (i.e., business and industry, community and faith-based organizations, schools, and health care systems) that support healthy lifestyles.

Long-term Outcomes

The sixth and seventh columns represent the ultimate goals to be attained by moving SC toward a healthy weight.

Healthy Weight. All of the activities and intermediate outcomes described are intended to increase the percentage of South Carolinians at a healthy weight. Secondarily, moving the population toward a healthy weight may aid in the reduction of health disparities in SC.

Better Health. Ultimately, reducing overweight and obesity can tremendously impact the prevalence and incidence of certain chronic diseases/conditions and will reduce the burden and economic impact of these diseases/conditions in SC.

Milestone 3: *Improved health of all populations who are affected by the burden of obesity and chronic diseases.*

Obesity State Plan Goals	Other Relevant Plans
1. Increase the percentage of South Carolinians and adults who meet the current age specific recommendations for regular physical activity.	**Coach:** School based programs, community activities, locating walking/biking areas **Palmetto Project:** Heart & Soul Project **Prevention Partners:** Employee insurance program **USC Prevention Research Center** **WIC State Nutrition:** Education/Breastfeeding Plan **USC Sumter:** Sumter County Active Lifestyles Impact Objectives **USC School of Medicine:** Community Nutrition Network (USC/Duke partnerships) **SCCPPA:** Working to bring about improved health & quality of life for all people in SC by encouraging & facilitating increased participation in regular physical exercise
2. Increase the percentage of South Carolina children and adults who consume at least five servings of fruits and vegetables a day.	**Coach:** Expanding breakfast program; vending machines; parent education **Palmetto Project:** Heart & Soul Project **Prevention Partners:** Employee insurance program **WIC State Nutrition:** State Farmer's Market Plan **DHEC/Cancer:** DHEC/SCCA Cancer plan will address 5-A-Day (not available until 7/05)
3. Increase the percentage of South Carolina mothers who breast-feed for at least six months.	**Coach:** Parent education task force goal **Prevention Partners:** Employee insurance program **WIC State Nutrition:** Education/Breastfeeding Plan
4. Increase the percentage of South Carolina children and adults who achieve and maintain a healthy weight. Increase the percentage of South Carolina children who watch two or fewer hours of screen time per day.	**Coach:** TV Turn off Week 4/25-5/1/05 **Palmetto Project:** Heart & Soul Project **Prevention Partners:** Employee insurance program **WIC State Nutrition:** Education/Breastfeeding Plan

Continued on next page

	DHEC/Minority Health: AMEC Strategic Health Plan; OMH Initiatives – "It's Your Health Take Charge" Calendar 2005 **DHHS:** Launched a small pilot in Anderson, Oconee, & Pickens counties to have BMI assessed on children age 8 & up during physical office visits **United Way of Midlands:** Funds two initiatives that address childhood obesity with Palmetto Health Richland & Fairfield Behavioral Health Services
5. Decrease the burden of obesity and obesity-related chronic diseases.	**Coach:** Improving the nutrition & physical environments **Palmetto Project:** Heart & Soul Project **Prevention Partners:** Employee insurance program **USC Prevention Research Center** **WIC State Nutrition:** Education/Breastfeeding Plan **SC Primary Health Care Assoc:** South East Disparities Collaborative of SC
6. Increase the number of research projects in South Carolina related to obesity prevention and control.	**Coach:** School based intervention surveys/projects that will relate to obesity prevention and control **Prevention Partners:** Employee insurance program **Companion Healthcare:** SC Coalition for Obesity Prevention & Education which dispenses educational DVDs on obesity prevention to all elementary schools in SC. **USC Prevention Research Center** **Clemson:** The EXPORT Center – a Clemson & Voorhees College Partnership

	LEVEL	APPLICATION
Policy & Environmental Strategies (Systems - Level Change)	**Society**	Developing and enforcing state policies and laws that can increase beneficial health behaviors. Developing media campaigns that promote public awareness of the health need and advocacy for change. **Examples:** Partnering with the Department of Agriculture to increase facilities (Farmer's Market programs) for increasing the availability of fruits and vegetables; improving the quality of all foods and beverages sold in schools; increasing incentives for the planning and development of healthier menus in communities; developing statewide media campaigns promoting the need for environments t
	Community	Coordinating the efforts of all members of a community (organizations, community leaders, and citizens) to bring about change. Developing and enforcing local policies that support beneficial health behaviors. **Examples:** Collaboration among community leaders to influence social norms and policies about nutrition; forming a community coalition to assess availability of high quality, nutritious foods in neighborhoods and local food establishments; local physical activity and nutrition coalitions develop educational presentations for other groups; developing a media advocacy strategy promoting the need for environments that support healthy eating; working with local community groups to establish
	Organizational	Changing the policies, practices, and physical environment of an organization (e.g., a workplace, health care setting, a school/child care, a faith organization, or another type of community organization) to support behavior change. **Examples:** Setting policy about healthy foods to be included in all menus planned for events; sponsoring school, faith organization, and worksite nutrition events, including healthy eating messages in newsletters and websites; adoption of worksite policies that provide time off or flex time during work hours for physical activity; establishing a policy allowing community members access to indoor and outdoor school facilities before and after regular school hours.
Individual Interpersonal Strategies	**Interpersonal**	Recognizing that groups provide social identity and support, interpersonal interventions target groups, such as family members or peers. **Examples:** Written information given to parents; training lay health advisors; developing buddy systems and support groups like weight management clubs.
	Individual	Motivating change in individual behavior by increasing knowledge, or influencing attitudes or challenging beliefs. **Examples:** Offering cooking classes; developing booths and displays for county fairs and community events; offering one-on-one counseling; targeting behavior change through media campaigns (posters, billboards, newspaper stories, and radio/television/newspaper advertisements.)

The Development of Healthy People 2010 Goals and Objectives

Healthy People 2010 represents the ideas and expertise of a diverse range of individuals and organizations concerned about the Nation's health. The Healthy People Consortium—an alliance of more than 350 national organizations and 250 State public health, mental health, substance abuse, and environmental agencies—conducted three national meetings on the development of Healthy People 2010. In addition, many individuals and organizations gave testimony about health priorities at five Healthy People 2010 regional meetings held in late 1998.

On two occasions—in 1997 and in 1998—the American public was given the opportunity to share its thoughts and ideas. More than 11,000 comments on draft materials were received by mail or via the Internet from individuals in every State, the District of Columbia, and Puerto Rico.

The final Healthy People 2010 objectives were developed by teams of experts from a variety of Federal agencies under the direction of Health and Human Services Secretary Donna Shalala, Assistant Secretary for Health and Surgeon General David Satcher, and former Assistant Secretaries for Health. The process was coordinated by the Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services.

Healthy People 2010 Goals

Goal 1: Increase Quality and Years of Healthy Life

The first goal of Healthy People 2010 is to help individuals of all ages increase life expectancy and improve their quality of life.

Goal 2: Eliminate Health Disparities

The second goal of Healthy People 2010 is to eliminate health disparities among segments of the population, including differences that occur by gender, race or ethnicity, education or income, disability, geographic location, or sexual orientation. This section highlights ways in which health disparities can occur among various demographic groups in the United States.

The Nation's progress in achieving the two goals of Healthy People 2010 will be monitored through 467 objectives in 28 focus areas. Many objectives focus on interventions designed to reduce or eliminate illness, disability, and premature death among individuals and communities. Others focus on broader issues, such as improving access to quality health care, strengthening public health services, and improving the availability and dissemination of health-related information. Each objective has a target for specific improvements to be achieved by the year 2010.

How Healthy People 2010 Will Improve the Nation's Health

One of the most compelling and encouraging lessons learned from the Healthy People 2000 initiative is that we, as a Nation, can make dramatic progress in improving the Nation's

health in a relatively short period of time. For example, during the past decade, we achieved significant reductions in infant mortality. Childhood vaccinations are at the highest levels ever recorded in the United States. Fewer teenagers are becoming parents. Overall, alcohol, tobacco, and illicit drug use is leveling off. Death rates for coronary heart disease and stroke have declined. Significant advances have been made in the diagnosis and treatment of cancer and in reducing unintentional injuries.

But we still have a long way to go. Diabetes and other chronic conditions continue to present a serious obstacle to public health. Violence and abusive behavior continue to ravage homes and communities across the country. Mental disorders continue to go undiagnosed and untreated. Obesity in adults has increased 50 percent over the past two decades. Nearly 40 percent of adults engage in no leisure time physical activity. Smoking among adolescents has increased in the past decade. And HIV/AIDS remains a serious health problem, now disproportionately affecting women and communities of color.

Healthy People 2010 will be the guiding instrument for addressing these and emerging health issues, reversing unfavorable trends, and expanding past achievements in health.

Community partnerships, particularly when they reach out to nontraditional partners, can be among the most effective tools for improving health in communities.

For the past two decades, Healthy People has been used as a strategic management tool for the Federal Government, States, communities, and many other public- and private sector partners. Virtually all States, the District of Columbia, and Guam have developed their own Healthy People plans modeled after the national plan. Most States have tailored the national objectives to their specific needs.

Businesses; local governments; and civic, professional, and religious organizations also have been inspired by Healthy People to print immunization reminders, set up hotlines, change cafeteria menus, begin community recycling, establish worksite fitness programs, assess school health education curriculums, sponsor health fairs, and engage in myriad other activities.

Everyone Can Help Achieve the Healthy People 2010 Objectives

Addressing the challenge of health improvement is a shared responsibility that requires the active participation and leadership of the Federal Government, States, local governments, policymakers, health care providers, professionals, business executives, educators, community leaders, and the American public itself. Although administrative responsibility for the Healthy People 2010 initiative rests in the U.S. Department of Health and Human Services, representatives of all these diverse groups shared their experience, expertise, and ideas in developing the Healthy People 2010 goals and objectives.

Healthy People 2010, however, is just the beginning. The biggest challenges still stand before us, and we all have a role in building a healthier Nation.

Regardless of your age, gender, education level, income, race, ethnicity, cultural customs, language, religious beliefs, disability, sexual orientation, geographic location, or occupation, Healthy People 2010 is designed to be a valuable resource in determining how you can participate most effectively in improving the Nation’s health. Perhaps you will recognize the

need to be a more active participant in decisions affecting your own health or the health of your children or loved ones. Perhaps you will assume a leadership role in promoting healthier behaviors in your neighborhood or community. Or perhaps you will use your influence and social stature to advocate for and implement policies and programs that can improve dramatically the health of dozens, hundreds, thousands, or even millions of people.

A Systematic Approach to Health Improvement

Healthy People 2010 is about improving health—the health of each individual, the health of communities, and the health of the Nation. However, the Healthy People 2010 goals and objectives cannot by themselves improve the health status of the Nation. Instead, they need to be recognized as part of a larger, systematic approach to health improvement.

This systematic approach to health improvement is composed of four key elements:

- Goals
- Objectives
- Determinants of health
- Health status

Leading Health Indicators

The Leading Health Indicators reflect the major public health concerns in the United States and were chosen based on their ability to motivate action, the availability of data to measure their progress, and their relevance as broad public health issues.

The Leading Health Indicators illuminate individual behaviors, physical and social environmental factors, and important health system issues that greatly affect the health of individuals and communities. Underlying each of these indicators is the significant influence of income and education.

The process of selecting the Leading Health Indicators mirrored the collaborative and extensive efforts undertaken to develop Healthy People 2010. The process was led by an interagency work group within the U.S. Department of Health and Human Services. Individuals and organizations provided comments at national and regional meetings or via mail and the Internet. A report by the Institute of Medicine, National Academy of Sciences, provided several scientific models on which to support a set of indicators. Focus groups were used to ensure that the indicators are meaningful and motivating to the public.

For each of the Leading Health Indicators, specific objectives derived from Healthy People 2010 will be used to track progress. This small set of measures will provide a snapshot of the health of the Nation. Tracking and communicating progress on the Leading Health Indicators through national- and State-level report cards will spotlight achievements and challenges in the next decade. The Leading Health Indicators serve as a link to the 467 objectives in *Healthy People 2010* and can become the basic building blocks for community health initiatives.

The Leading Health Indicators are intended to help everyone more easily understand the importance of health promotion and disease prevention and to encourage wide participation in improving health in the next decade. Developing strategies and action plans to address one or more of these indicators can have a profound effect on increasing the quality of life and the years of healthy life and on eliminating health disparities—creating *healthy people in healthy communities.*

Health Impact of Overweight and Obesity

Overweight and obesity substantially raise the risk of illness from high blood pressure, high cholesterol, type 2 diabetes, heart disease and stroke, gallbladder disease, arthritis, sleep disturbances and problems breathing, and certain types of cancers. Obese individuals also may suffer from social stigmatization, discrimination, and lowered self-esteem.

Populations With High Rates of Overweight and Obesity

More than half of adults in the United States are estimated to be overweight or obese. The proportion of adolescents from poor households who are overweight or obese is twice that of adolescents from middle- and high-income households. Obesity is especially prevalent among women with lower incomes and is more common among African American and Mexican American women than among white women. Among African Americans, the proportion of women who are obese is 80 percent higher than the proportion of men who are obese. This gender difference also is seen among Mexican American women and men, but the percentage of white, non-Hispanic women and men who are obese is about the same.

Reducing Overweight and Obesity

Obesity is a result of a complex variety of social, behavioral, cultural, environmental, physiological, and genetic factors. Efforts to maintain a healthy weight should start early in childhood and continue throughout adulthood, as this is likely to be more successful than efforts to lose substantial amounts of weight and maintain weight loss once obesity is established.

A healthy diet and regular physical activity are both important for maintaining a healthy weight. Over time, even a small decrease in calories eaten and a small increase in physical activity can help prevent weight gain or facilitate weight loss. It is recommended that obese individuals who are trying to lose substantial amounts of weight seek the guidance of a health care provider.

Dietary and Physical Activity Recommendations

The *Dietary Guidelines for Americans* recommend that to build a healthy base, persons aged 2 years and older choose a healthful assortment of foods that includes vegetables; fruits; grains (especially whole grains); fat-free or low-fat milk products; and fish, lean meat, poultry, or beans. The guidelines further emphasize the importance of choosing foods that are low in saturated fat and added sugars most of the time and, whatever the

food, eating a sensible portion size. It is recognized, however, that this guidance may be particularly challenging when eating out because the consumer may be offered large portion sizes with unknown amounts of saturated fat and added sugars.

The *Dietary Guidelines for Americans* recommend that all adults be more active throughout the day and get at least 30 minutes of moderate physical activity most, or preferably all, days of the week. Adults who are trying to maintain healthy weight after weight loss are advised to get even more physical activity. The guidelines also recommend that children get at least 60 minutes of physical activity daily and limit inactive forms of play such as television watching and computer games.

Regular physical activity is associated with lower death rates for adults of any age; even when only moderate levels of physical activity are performed. Regular physical activity decreases the risk of death from heart disease, lowers the risk of developing diabetes, and is associated with a decreased risk of colon cancer. Regular physical activity helps prevent high blood pressure and helps reduce blood pressure in persons with elevated levels.

HP 2010 Objectives used for the foundation for the Moving South Carolina Towards a Healthy Weight: Promoting Healthy Lifestyles and Healthy Communities

For planning purposes, the following objectives regarding the prevalence of overweight and obesity and related risk factors were used to build the six goals of the Moving South Carolina Towards a Healthy Weight Plan:

- **Objective 16.19.** Increase the proportion of mothers who breastfeed their babies.
- **Objective 19-1.** Increase the proportion of adults who are at a healthy weight.
- **Objective 19.2.** Reduce the proportion of adults who are obese.
- **Objective 19.3.** Reduce the proportion of children and adolescents who are overweight or obese
- **Objective 19.5.** Increase the proportion of persons aged 2 years and older who consume at least two daily servings of fruit.
- **Objective 19.6.** Increase the proportion of persons aged 2 years and older who consume at least three daily servings of vegetables, with at least one-third being dark green or orange vegetables.
- **Objective 22-1.** Reduce the proportion of adults who engage in no leisure-time physical activity.
- **Objective 22.2.** Increase the proportion of adults who engage regularly, preferably daily, in moderate physical activity for at lease 30 minutes per day.
- **Objective 22-6.** Increase the proportion of adolescents who engage in moderate physical activity for at least 30 minutes on 5 or more of the previous 7 days.

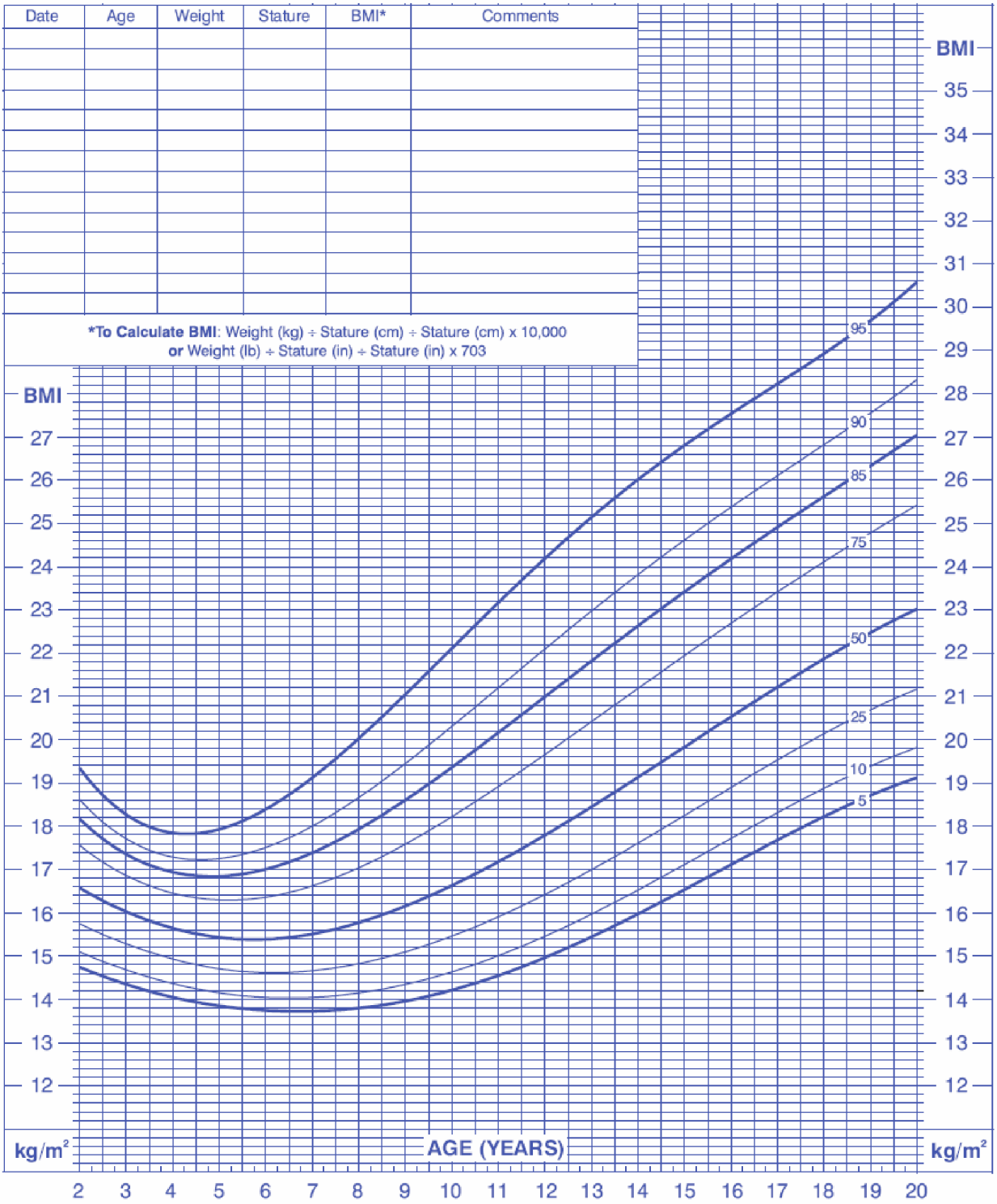
2 to 20 years: Boys
Body mass index-for-age percentiles

NAME _____

RECORD # _____

Date	Age	Weight	Stature	BMI*	Comments

***To Calculate BMI**: Weight (kg) ÷ Stature (cm) ÷ Stature (cm) x 10,000
or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703



Published May 30, 2000 (modified 10/16/00).

SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts

CDC
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2 to 20 years: Girls
Body mass index-for-age percentiles

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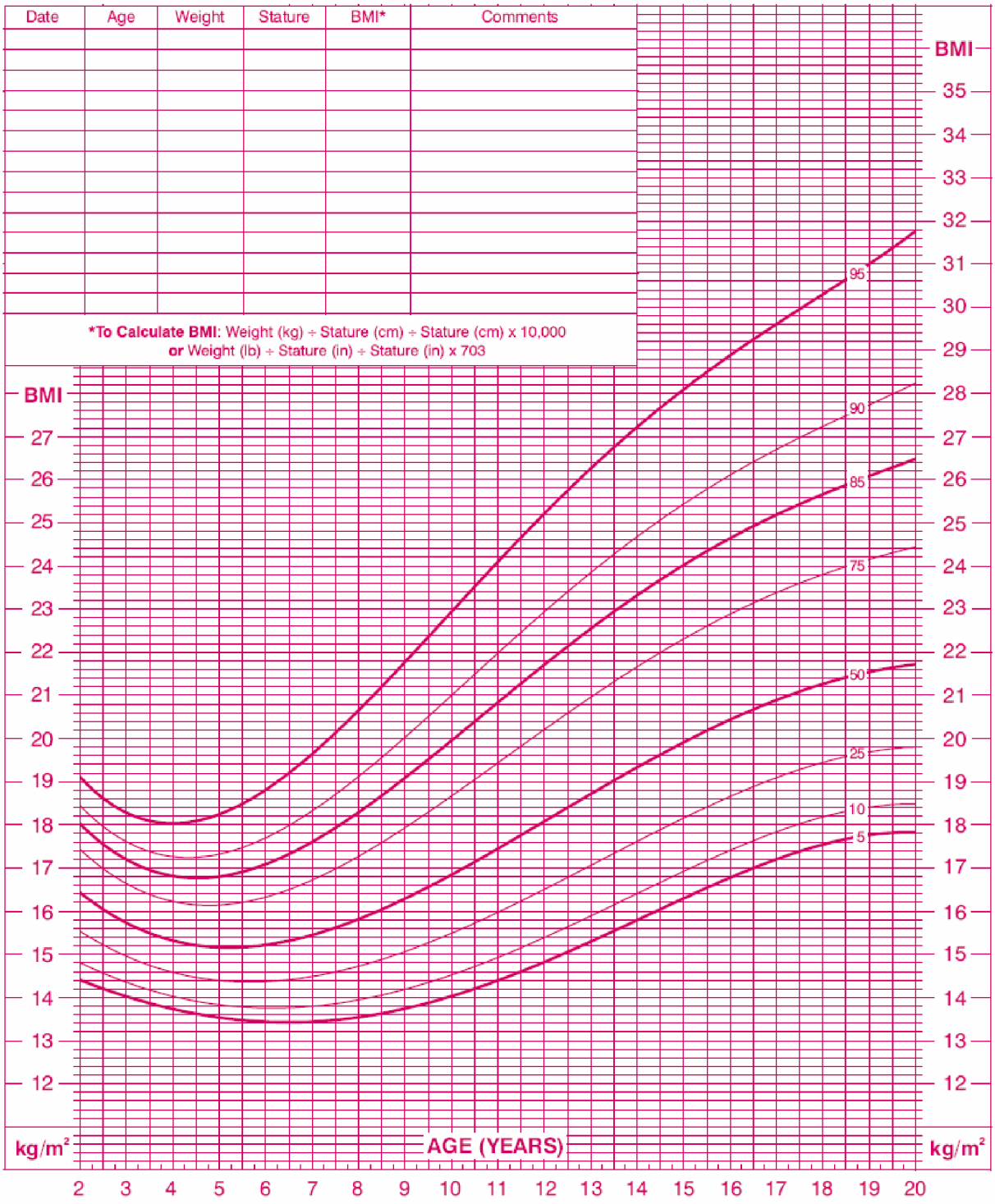

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SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts

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Body Mass Index Table

	Normal						Overweight					Obese										Extreme Obesity															
BMI	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54
Height (inches)	Body Weight (pounds)																																			
58	91	96	100	105	110	115	119	124	129	134	138	143	148	153	158	162	167	172	177	181	186	191	196	201	205	210	215	220	224	229	234	239	244	248	253	258
59	94	99	104	109	114	119	124	128	133	138	143	148	153	158	163	168	173	178	183	188	193	198	203	208	212	217	222	227	232	237	242	247	252	257	262	267
60	97	102	107	112	118	123	128	133	138	143	148	153	158	163	168	174	179	184	189	194	199	204	209	215	220	225	230	235	240	245	250	255	261	266	271	276
61	100	106	111	116	122	127	132	137	143	148	153	158	164	169	174	180	185	190	195	201	206	211	217	222	227	232	238	243	248	254	259	264	269	275	280	285
62	104	109	115	120	126	131	136	142	147	153	158	164	169	175	180	186	191	196	202	207	213	218	224	229	235	240	246	251	256	262	267	273	278	284	289	295
63	107	113	118	124	130	135	141	146	152	158	163	169	175	180	186	191	197	203	208	214	220	225	231	237	242	248	254	259	265	270	278	282	287	293	299	304
64	110	116	122	128	134	140	145	151	157	163	169	174	180	186	192	197	204	209	215	221	227	232	238	244	250	256	262	267	273	279	285	291	296	302	308	314
65	114	120	126	132	138	144	150	156	162	168	174	180	186	192	198	204	210	216	222	228	234	240	246	252	258	264	270	276	282	288	294	300	306	312	318	324
66	118	124	130	136	142	148	155	161	167	173	179	186	192	198	204	210	216	223	229	235	241	247	253	260	266	272	278	284	291	297	303	309	315	322	328	334
67	121	127	134	140	146	153	159	166	172	178	185	191	198	204	211	217	223	230	236	242	249	255	261	268	274	280	287	293	299	306	312	319	325	331	338	344
68	125	131	138	144	151	158	164	171	177	184	190	197	203	210	216	223	230	236	243	249	256	262	269	276	282	289	295	302	308	315	322	328	335	341	348	354
69	128	135	142	149	155	162	169	176	182	189	196	203	209	216	223	230	236	243	250	257	263	270	277	284	291	297	304	311	318	324	331	338	345	351	358	365
70	132	139	146	153	160	167	174	181	188	195	202	209	216	222	229	236	243	250	257	264	271	278	285	292	299	306	313	320	327	334	341	348	355	362	369	376
71	136	143	150	157	165	172	179	186	193	200	208	215	222	229	236	243	250	257	265	272	279	286	293	301	308	315	322	329	338	343	351	358	365	372	379	386
72	140	147	154	162	169	177	184	191	199	206	213	221	228	235	242	250	258	265	272	279	287	294	302	309	316	324	331	338	346	353	361	368	375	383	390	397
73	144	151	159	166	174	182	189	197	204	212	219	227	235	242	250	257	265	272	280	288	295	302	310	318	325	333	340	348	355	363	371	378	386	393	401	408
74	148	155	163	171	179	186	194	202	210	218	225	233	241	249	256	264	272	280	287	295	303	311	319	326	334	342	350	358	365	373	381	389	396	404	412	420
75	152	160	168	176	184	192	200	208	216	224	232	240	248	256	264	272	279	287	295	303	311	319	327	335	343	351	359	367	375	383	391	399	407	415	423	431
76	156	164	172	180	189	197	205	213	221	230	238	246	254	263	271	279	287	295	304	312	320	328	336	344	353	361	369	377	385	394	402	410	418	426	435	443

Source: Adapted from *Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report*.

Obesity
Report Card

(To be added at a later date)

Inventory of Partner Activities

(To be added at a later date)